Rediscovering Pathways to Compassionate Care, by Dr. Janice LeBel
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Is history plagued with repetition compulsion? Some important lessons learned from earlier generations seem to be forgotten and reinvented with the fanfare of a new discovery. This may be the case of the cyclical and parallel processes of restraint and seclusion reduction and elimination efforts and the infusion of sensory-based interventions to facilitate this important change in treatment culture and practice.

For more than two hundred (200) years, the pursuit of compassionate care has been linked with efforts to eliminate treatment violence and promote sensory intervention. Appealing to the five (5) well-known senses of: sight, sound, smell, touch, and taste and the two (2) lesser-recognized sensory experiences of proprioceptive and vestibular input has been an important part of changing treatment culture. Very early strategies to shape psychiatric practice considered and used sensory interventions such as: food, music, aroma, the appearance of the physical environment, physical exercise, rhythm, learning fine motor and gross motor skills, physical work and the development of occupational skills (1).

One of the earliest efforts to replace the use of restraint and seclusion with pro-social sensory experience was the development of moral treatment, initiated by the William Tuke and his family in England in 1792 (2). Tuke was a philanthropist whose Quaker-based philosophy emerged at the same time Philippe Pinel was removing the chains from the mentally ill people he treated at Bicêtre in France. Tuke and his son, Samuel, emphasized the values of kindness and moral practice and opened a private facility aptly called, "The Retreat at York," in response to appalling conditions they witnessed at the public York Asylum. The Retreat quickly distinguished itself for substituting coercive practices with kindness, humane treatment, teaching self-control and the therapeutic use of occupational tasks (3). Pinel, while widely credited with initiating anti-restraint practice, actually promoted intervention-substitution strategies that were not sensory-based and were frankly aversive and coercive. His strategies included: "threatening patients with the camisole or gilet de force;" the "estimable effects of coercion; the happy effects of intimidation without severity; of oppression without violence; and of triumph, without outrage" (4, 2).

The empathic work of the Tuke family fueled and informed the advancement of the "Non-Restraint Movement" in the United Kingdom. After the Tukes, Robert Gardiner Hill, Edward Parker Charlesworth and John Conolly followed. Dr. Conolly was particularly recognized for eliminating mechanical restraint "on a scale so large as to silence all cavilling."(4). In 1839, he eliminated mechanical restraint in 4 months time at his 1,000 bed facility at Hanwell by creating a treatment environment intended to "impress with the sensations of a kind new world." He endorsed the importance of individualized treatment, exercise, spirituality, physical comforts: good food, bathing

regularly, environmental cleanliness and occupation. Central to Conolly's work was the concept of recovery; refusing "to condemn anyone to a life without hope" (1). He also recognized that "…in the management of children of tender years, many customs prevail which directly tend to irritate and spoil the growing brain. The system of mental and physical training generally adopted for children and youth of either sex, and their general treatment, are so far from being adapted to secure a sound mind in a sound body as to be little better than a satire on the common sense of mankind" (1).

Almost one hundred (100) years later, restraint and seclusion reduction and elimination efforts in America reflected similar sensory intervention replacement thinking. In Massachusetts, Dr. Vernon Briggs, a Boston psychiatrist, passionately and successfully pursued restraint legislation in 1911 to eliminate patient abuse he witnessed in psychiatric facilities. He lobbied for the passage of Massachusetts first restraint statute to restrict its use. Dr. Briggs extolled the virtues of some public hospitals, citing the good work at Northampton and Danvers State Hospitals, "In two of our best hospitals no restraint has been used for ten years or more … while the private and general hospitals are only too ready to throw patients into restraint," (5). Simultaneously, he promoted the "Occupation Bill" in the Massachusetts Legislature to, "…show how the use of occupational therapy could take the place of restraint in the treatment and care of [our] mental patients" (5). This new law required state institutions to provide, "…instruction to nurses, attendants and patients in such arts, crafts, manual training, kindergarten and other kinds of occupation as may be appropriate for the patients of such institutions to learn…" (5).

Nearly a century after Dr. Briggs important work, Massachusetts and several other states are actively involved in new restraint and seclusion elimination initiatives. Many of the state efforts were developed in response to the Hartford Courant's Pulitzer prize-wining series of articles on restraint-related deaths (6, 7). However, some states such as, Massachusetts and Pennsylvania, embarked on restraint and seclusion elimination initiatives without media-impetus. Massachusetts began an initiative to reduce and ultimately eliminate seclusion and restraint in child and adolescent-serving inpatient facilities more than five (5) years ago and has reduced the statewide use approximately eighty-five percent (85%). Pennsylvania began a process of eliminating seclusion and restraint in their nine (9) adult state hospitals almost ten (10) years ago and have set the goal of restraint and seclusion elimination, at all of these facilities, effective January 1, 2006 (8).

National leadership has bolstered all of the restraint and seclusion reduction/elimination initiatives. In 2003, the Substance Abuse Mental Health Services Administration launched a "National Call to Action to Eliminate Seclusion and Restraint," and the National Association of State Mental Health Program Directors, National Technical Assistance Center (NASMHPD-NTAC) created a comprehensive curriculum to reduce seclusion and restraint (9, 10). This curriculum has been taught to more than 2,000 participants representing forty-six state and territory delegations. Imbedded in the NASMHPD-NTAC curriculum are important restraint and seclusion prevention tools,

including sensory interventions and the development of alternative environments to promote comfort, appropriately called "Comfort Rooms."

Now, sensory interventions are emerging in psychiatric inpatient facilities in the United States. Specifically, occupational therapy practices are being more fully integrated into treatment strategies, crisis prevention plans and focal skill development for consumers and staff. Sensory assessments of individual "sensory diets" to determine whether someone is sensory-seeking or sensory-avoiding are providing important information for developing individualized repertoires of interventions designed to teach self-soothing and self-calming skills. Likewise, established nursing methods such as aromatherapy and therapeutic touch are also being used, including arm and hand massages, medicine ball massages, and the use of vibration (11).

Historically (and currently) psychiatric inpatient settings had Quiet Rooms. Quiet Rooms were paradoxically named, sensory-stripped rooms intended to promote quiet and restore calm - but seldom did. Now, hospitals are replacing Quiet Rooms with attractive sensory rooms for people in treatment to learn what helps calm them and what does not. For example, in Massachusetts, at Taunton State Hospital, a modest Snoezelen room was created for adolescents to learn about sensory preferences, assessing their response to stimulating and relaxing exercises, and developing new self-calming skills. Snoezelen technology originated in Holland more than thirty-five (35) years ago when sensory interventions were recognized as therapeutically beneficial for people with different types of impairment (12). Similarly, Cohannet Academy, another adolescent program at Taunton, developed a sensory room named, "The Getaway," and linked sensory interventions to the adolescent's emotional and behavioral regulation skill development, used as part of the program's overall Dialectical Behavior Therapy orientation. These on-unit room conversions incur a fraction of the cost of restraint room equipment. The Getaway was created through donations from the community and staff ingenuity. Moreover, converted sensory rooms create a pleasant, relaxing environment and removes visible, aversive stimuli from settings intended for healing and care.

Other rooms, such as Comfort Rooms, are also being created in psychiatric hospitals throughout the country. Comfort Rooms were developed by Gayle Bluebird, RN, a consumer-advocate, who worked at South Florida State Hospital and implemented Comfort Rooms to provide an on-unit haven and tool to help prevent the use of restraint and seclusion (10). Comfort Rooms, conceptually, differ somewhat from sensory rooms in that there is no sensory-experimentation or stimulation. Comfort Rooms are designed with consumers, for consumers, and intended to be a place to relax and restore.

It appears that history is repeating itself. The coercive-treatment tide seems be turning once again. As efforts to eliminate violence from treatment settings continue, there is increased recognition of the importance of attending to sensory needs, what Conolly called, "securing a sound mind in a sound body." Similarly, as restraint and seclusion are removed from intervention repertoires, the importance of creating restorative sensory

alternatives - likely not too dissimilar from Tuke's "Retreat" - is being recognized. The imperative for all treatment practitioners is to transmit these lessons learned, interrupt the cycle of intervention-amnesia, and perpetually hold the perspective of those we serve as our treatment compass.

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